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DEPARTMENT OF HEALTH	AND HUMAN SERVICES
CENTERS FOR MEDICARE	& MEDICAID SERVICES

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12	18/07		
TIPLE CONSTRUC	TION		•

PRINTED: 11/19/2007 FORM APPROVED OMB NO. 0938-0391

(EACH DEFICIE REGULATORY OF TAGE INITIAL COMME A follow-up survey 7, 2007, to deter with previous conseptember 28, 2 were based on ordirect support and the review of reports and admitted florings determine of compliance with in Client Protection (W 104) The governing be budget, and open the stand open coordinates with the standard open coordinates with the standard open the standard open coordinates with the standard open coordinat	09G094	A. BUIL			
(X4) ID SUMMARY (EACH DEFICIE REGULATORY OF REFIX TAG REGULATORY OF REGU				_	ج جامعہ
W 000) INITIAL COMME A follow-up survey, 2007, to deter with previous col September 28, 2 were based on o direct support and the review or reports and adm findings determine of compliance with in Client Protection (483,410(a)(1) Go The governing be budget, and open the standard op	LIER		STREET ADDRESS, CITY, STATE, ZIP COD 1934 9TH STREET, NW WASHINGTON, DC 20012		7/2007
A follow-up survey, 2007, to deter with previous con September 28, 2 were based on o direct support and the review or reports and admiting determine of compliance with in Client Protection 483,410(a)(1) Go The governing behalves, and open the STANDARE Based on observing of conditions are serviced desired.	Y STATEMENT OF DEFICIENCIES HENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION)	ID PREFD TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
Based on observe record review, the provided general following areas:	rvey was conducted on November ermine the facility's compliance condition level deficiencies cited on 2007. The findings of this survey observations, interviews with and administrative staff and clients, of records, including incident ministrative records. The survey nined that the facility remained out with the Condition of Participation	(W 00			
governing body for recognized and recognized and reaccordance with safety and due plus 2. Cross-refer to governing body for secured timely pervaluations when	clude: to W149, W125 and 148. The railed to ensure that all staff if reported allegations of abuse in h policies to ensure the health, process rights of its clients. to W212 and W225. The railed to ensure that the facility psychiatric and/or vocational	{W 12	1. See responses to W149, W125 and W225.		12/13/07 12/13/07

Any deficiency statement ending with an esterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued Prector of Deathlety

FORM CMS-2567(02-69) Pravious Versions Obsolete

Event ID: C5KJ12

Facility ID: 09(\$094

If continuation sheet Page 1 of 29

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CENTERS FOR MEDICARE & MEDICAID SERVICES	DEPARTMENT OF HEALTH	AND HUMAN SERVICES
	CENTERS FOR MEDICARE	& MEDICAID SERVICES

PRINTED: 11/19/2007 FORM APPROVED

STATEMEN	NT OF DEFICIONCIES	(X1) PROVIDER/SUPPLIER/CLIA	1040			<u> OMR NO</u>	<u>). 0938-</u> 0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION (X3) DATES SUILDING COMPLI		URVEY ETED	
		09 G094	B. WI	NG_			R
NAME OF	PROVIDER OR SUPPLIER			T	· · · · · · · · · · · · · · · · · · ·	11/0)7 <u>/</u> 2007
CAREC				6	REET ADDRESS, CITY, STATE, ZIP CODE 1934 8TH STREET, NW VASHINGTON, DC 20012		
(X4) ID	SUMMARY STA	TEMENT OF DEPICIENCIES		<u>. </u>			
PREFIX TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	1000	(X5) COMPLETION DATE
{W 122}		ge 1	{W 1:	221	The DeDC		
	The facility must ensprotections required This CONDITION is The facility failed to effective policies and implementation of its system [See W149]; allegations of neglect of unknown source, investigated thoroug failed to ensure that to the administrator owithin five working dis W156]. The effects of these	sure that specific client nents are met. In not met as evidenced by develop and implement develop and implement develop and implement failed to ensure that all stor abuse, as well as injuries were reported and hly [See W153 and 154]; and investigations were reported or designated representative ays of the incident [See	{ VV 1		The DoDS revised agency policy to me standards of the Departments of Health Disability Services. Training was provat all levels on the requirements of the November 3, 2007. On November 10, 2 DoDS convened a meeting of all managand provided training on incident report investigation. The Director of Operation a meeting of the Nursing Department at Department, where the DoDS trained all Residential Directors (RDs), RN Superv Designated Nurses, and Medication Nur November 14, 2007 on the Incident Politications and investigation Incident Management Coordinator (IMC investigation training with Labor Relation Associates from November 27-30, 2007 provided her with additional training on complete, and timely investigative proceduced to provide training, as support and oversight on the incident management and contraining on the incident management and oversight on the incident management and incident and in	and ided to staff policy on 2007 the gement staff ting and as convened ad the DD I QMRPs. risors, see on cy, s. The c) attended ons that thorough, dures, The mentoring,	
	me remote of the tSCII	ity to protect its clients from heir general safety and well			System to custife that staff and profession	1 ole	
1	peing.			į į	providing services comply with the policing	y and	12/13/07
W 125	483.420(a)(3) PROTI RIGHTS	ECTION OF CLIENTS	W 13				10/2/
1		·					
	r neretore, the racility Individual clients to ex of the facility, and as	are the rights of all clients. must allow and encourage cercise their rights as clients citizens of the United States, lile complaints, and the right] }	See response to W122. The QMRP has betrained on documenting, reporting, notifamily, attorney, gnardism, administrator, DOH and investigating incidents.	a -	12/13/07
r e h c	pased on Interview ar revisit on November 7 ensure each client's n lave his/her complain	not met as evidenced by: not record review during the record review dur					

Event ID; C5KJ12

Facility ID: 09G094

If continuation sheet Page 2 of 29

DEPAR CENTE	TMENT OF HEALTH	I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 11/19/2007 I APPROVED
TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE 5 COMPL	. 0938-0391 EURVEY ETED	
		09G094	B. Wil	NG.			R
NAME OF	PROVIDER OR SUPPLIER			80	TREET ADDRESS, CITY, STATE, ZIP CODE	11/0	7/2007
CAREC	0 0\$				6934 9TH STREET, NW WASHINGTON, DC 20012		
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEPED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	· ·X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE AUTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDBE	(X5) COMPLETION DATE
W 125	Continued From pa #4)	ge 2	W	125	5		
	The finding Includes	5:					
	Client #4 informed a punched him in the Qualified Mental Re (QMRP) on Novem	9. On October 28, 2008, staff that Client #1 had face. Interview with the tardation Professional					
	peer-on-peer abuse accordance with fac QMRP indicated the clients at the time the there was no written review to verify that	hat the allegation of had not been reported in had not been reported in had not been reported in hilly policies. Although the two he client made his allegation, a documentation available for the client's complaint had in addition, there was no					
W 148	evidence that Client to outside entities, Ir remains involved in facility policies, to er received appropriate	#4's allegation was reported acluding his mother (she his care), in accordance with a sure that his complaint a review.	W 1	148			
	The facility must not parents or guardlan changes in the client	ify promptly the client's of any significant incidents, or is condition including, but not ness, accident death, abuse			Sec response to W125.	i	12/13/67
	Based on interview a revisit on November consistently notify the significant incidents, physical abuse, for o In the facility. (Cllent	Including allegations of ne of the five clients residing #4)					
RM CMS-256	7(02-08) Previous Versions C	bsolete Event ID: CSKU12	 -	Fq	ality ID: 09G084 If contin	uation sheet	Page 3 of 29

@330

	OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML	JULIPLE CONSTRUCTION	OMB N	M APPRO O_ 0938-0
		HOWINGER,	A. BUIL	DING	(X3) DATE	SURVEY LETED
A145 05		09G084	B. WING	3	_	R
	PROVIDER OR SUPPLIER				11,	07/2007
AREC	O 05		[STREET ADDRESS, CITY, STATE, ZIP 6934 9TH STREET, NW	, CODE	
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES		WASHINGTON, DC 20012	· -	
TAG	REGULATORY OR L	SCIDENTIFYING INFORMATION	PREFIX YAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD BE	(XG) COMPLET DATE
W 148	Continued From pa	ge 3	W 14			<u> </u>
	The finding includes	5;	,			
		9. On October 28, 2008, staff that Client #1 had			-	
	Qualified Mental Re	race. Interview with the				
	6:00 PM. revenied to	per 7, 2007, at approximately				
1	evidence that Client	had not been reported in lifty policies. There was no #4's mother (who remained				
1.1	active in his care) wa allegation.	as made aware of her son's				
.	t should be noted, he	owever, that the facility had notified his mother promptly			·	
#	1 on September 30	2007				
149) 4	183.420(d)(1) STAFF CLIENTS	TREATMENT OF	{W 149}	•		
		elop and implement written		See response to W125. The police "incident." The DoDS has held, are to hold, numerous training		
П	ilstreatment, neglect	or abuse of the client.		Management. The DoDS will ensite clear that an individual second	ure that all staff	
		ot met as evidenced by: -ws, review of Client #4's	ĺ	the aggressor, but that stuff are according to the control of the	ountable. The	
of fa	the facility's incident cility failed to implem	m records as well as review management policy, the		incident, and must be managed according to the client may need additional bet	ording to policy.	
en an	Isure that allegations of investigated in according	of abuse were reported	į s	and planning, and the environment in distribution as much as possible to previous initiative of harm to others through the land to be between the property of his property in the property of	must be	
	- 1 - 19 4 BILLONS. (NES	Idents #1, #2, #3, #4, #5)	'n	haladaptive behaviors.	n a client's	12/13/07
Th	e finding includes;			;		,
	2-99) Previous Versione Oban			•		

DEPARTMENT OF HEAL	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			PRINTE	D: 11/19/2007
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	J	ULTIPLE CONSTRUCTION	(X3) DATE	
		l l	LDING	— COMPI	LETED
NAME OF PROVIDER OR SUPPLIE	09G094	B. WIN	IG	14/	R 07/2007
GARECO 05	R -		STREET ADDRESS, CITY, STATE, Z	IP CODE	U112007
* * * * * * * * * * * * * * * * * * *	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(Xā) COMPLETION DATE
had been one inc since the Septem survey. The corre reviewed. At 9:20 had been no othe approximately 1:3 Retardation Profe that no other incid September 28, 20 LPN Designated N time, stated that si	2007, at 9:14 AM, interview with ctor (RD) revealed that there dent reported and investigated ber 28, 2007 recertification asponding documentation was AM, the RD stated that there incidents reported. At 5 PM, the Qualified Mental salonal (QMRP) also indicated ents had occurred since the 07 recertification survey. The lurse, who was present at the ne was unaware of any other ired dursing care (expect for	{W 14			
medical chart that allegation of physic 2007, at 9:30 PM, documented that a altercation between progress note furth assessed the client He did, however, do Tylenol 650 mg that At 5:30 PM, the QM incident. She state that evening, working	"counselor" reported and Client #4 and a peer. The er indicated that the nurse had and found no sign of injury. I comment having administered to evening "for paln." IRP was asked about the cut that she had been onsite and with Client #4 in the division.				
medication nurse the in the face. The nurse the face. The nurse the face of th	the QMRP, Client #4 told the at Client #1 had punched him the promptly came to the iffied the QMRP. She said dianyone about the alleged real arrived. The QMRP ad the two clients; however, documentation available to				
M CMS-2567(02-93) Previous Versions	Obsolete Event ID: C5KJ12	F	azilly (D; 09G0B4	If continuation sheet I	Page 5 of 29

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PRINTED: 11/19/2007

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB<u>NO. 0938-03</u>9 (X1) PROVIDER/SUPPLIER/CLIA AND RLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 09G094 NAME OF PROVIDER OR SUPPLIER 11/07/2007 STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 05 6934 9TH STREET, NW WASHINGTON, DC 20012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION TAG DEFICIENCY (W 149) Continued From page 5 (W 149) verify that an investigation had been initiated. The other staff on duty at that time reportedly had been in the basement with other clients. The QMRP further indicted that she had not viewed this as an incident because she categorized Client #4's allegation as a false accusation. Neither she nor the nurse had documented the allegation of abuse on an incident report. The QMRP and LPN Designated Nurse both stated that making false accusations was not one of Client #4's known target behaviors. At approximately 6:05 PM, the QMRP was asked whether the facility's policy addressed allegations of physical abuse. She replied that she planned to make a reference to Client #4's accusation when she wrote her October QMRP Monthly Note in the client's record. When pressed further about policies on reporting such allegations, at 6.08 PM, she expressed doubt that their policies required an incident report it/when an allegation involved peer on peer allegations: "not individuals... staff, that's an incident." The facility's Policies and Procedures Manual (manual) was reviewed, beginning at approximately 6:10 PM. At the outset, the manual provided a list of definitions, which included the following: Abuse: "The wrongful treatment of an individual... including, but not limited to, another individual being served, an employee..." Incidents: Included was "Allegation of abuse," which was marked with an asterisk. The list indicated that an asterisk meant this was categorized by the agency as a "Serious Reportable Incident, FORM CMS-2567(02-88) Previous Versions Obsolete Event ID: C5KJ12

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Facility ID: 09G094

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CENTERS FOR MED	EALTH AND HUMAN SERVICES ICARE & MEDICAID SERVICES					FORM	D: 11/19/200 MAPPROVE
TATEMENT OF DEFICIENCIE PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONSTRI LDING	UCTION.		(X3) DATE:	0. 0938-039 SURVEY ETED
	09G094	₽. WIN	G		_		R
NAME OF PROVIDER OR SU CARECO 05	PLUER		6934 DTH STR	S, CITY, STATE, ZIF EET, NW DN, DC 20012	CODE	11/	0 7/20 07
	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PR(OVIDER'S FLAN OF CORRECTIVE ACT REFERENCED TO T DEFICIENCE	TON SHOU HE APPRO	IDDE	(X6) COMPLETION DATE
(W 149) Continued Fr	om page 6	{W 14	9}				
requires imm investigation	ortable Incident: "A reportable						
Abuse" was li Incident on the for documenti	Incident Management Policy, 17, revealed that "Allegation of 18 serious Reportable 18 incident report form that was used all Incidents, regardless of 18 the facility's policy,	ed		·			
two, some of a required treatr For example, a 30, 2007 and i report, describ the shoulder who have the skin.	oted that Clients #1 and #4 have a istory of altercations between the which led to serious injuries that ment at hospital emergency rooms an incident report dated Septembets corresponding investigation and how Client #1 bit Client #4 on ith little provocation. The bite Client #4 was taken to an orm for immediate care and nent.						
agency's Direct reviewed their all nurses, RDs Management C	ther noted that at approximately MRP and RD both stated that the tor of Disability Services had noident Management Policies with QMRPs and the Incident oordinator at a "program meeting held Thursday, November	1				·	
**************************************	· · · · · · · · · · · · · · · · · · ·						
M CMS-2867(02-88) Previous Ver	Sions Obsolete Event ID: CSK/1	l2 Fa	idility ID: 09@094		of management	tion of the second	Page 7 of 29

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 11/19/200 MAPPROVE D: 0938-039
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE	SURVEY
		09@094	B. WING_			R
NAME OF E	PROVIDER OR SUPPLIER O 05		e	REET ADDRESS, CITY, STATE, ZIP CODE 934 9TH STREET, NW VASHINGTON, DC 20012	_	07/2007
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OLU D BE	(X5) COMPLETION DATE
(W 149)		ge 7 tember 28, 2007 survey	(W 149)	-		
	failed to establish a ensure the health a	and record review, the facility nd/or implement policies to nd safety of four of the six se facility. (Clients #1, #2, #4				
	The findings include	9:				
	of the State agency	to document the notification of significant incidents, in incident management		1. See response to W125.	•	12/13/07
ĺ	incident reports, involved a September 25-27 four incidents of abusource documented January 2007 and Streview of the facility interview falled to shadministrator and the	3. Review of the facility's estigations and client records 7, 2007 revealed evidence of use and one injury of unknown to have occurred between eptember 2007. Continued s incident reports and/or low evidence that the e Department of Health were live aforementioned incidents.				(
	Qualified Mental Ref (QMRP) was conduct at 3:21 PM and 3:44 Indicated that staff was were informed of the should have docume Incident report prior to QMRP stated that the (DOH) was to be not	esident Director (RD) and ardation Professional ardation Professional ardation Professional ardation Professional ardation Professional article articl				

Event ID: C5KU12

Facility ID: 09G094

if continuation sheet Page 8 of 29

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 11/19/2007 APPROVED : 0938-0391
D PLAN (TOF DEFICIENCIES OF CORRECTION	(X1) PROMIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION (X3) DATE COMP		URVEY
		09 G094	B. WIN	lG	1	R
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		7/2007
CARECC				6934 9TH STREET, NW WASHINGTON, DC 20012	<u>.</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	. ID PREFI; TAG		OULD BE	(X5) COMPLETION DATE
{W. 149}	Continued From page 24 hours.	ge 8	(W 14	19}		
	policy on Septembe were categorized in reportable incidents and injuries of unknoserious reportable in policy, staff were recthe case manager, the case manager of parent or guardian frincidents. Incident recompleted on "all seand the incident republishment and the incident republishment and the factorial policy of the parent of the pa	y's "Incident Management" or 26, 2007 revealed incidents to both reportable and serious. Allegations of abuse, neglect own source were identified as acidents. According to the quired to "immediately call" the DOH, and the client's or all serious reportable report forms were to be prious reportable incidents" out was to be forwarded to the s. However, the survey ality had not consistently ency of the incidents, in policies.				
;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;	Implementation of the of its Incident Manage by the following: Cross-refer to W153 incident reports, investor September 25, 20 revealed two allegatic January 17, 2007 are allegation of verbal a QMRP was Interviewed 3:44 PM. She stated buse were to be invitable incidents was allegation of the invitable incidents was allegated this; "allegorable incidents was allegorable incidents	to ensure consistent te "investigation" component gement policies, as evidenced and W154. Review of estigations and client records 207 and September 27, 2007, ons of abuse and/or neglect and April 8, 2007) and one abuse (May 14, 2007). The red on September 25, 2007, ted that all allegations of restigated and completed days. Review of the facility's nit" policy on September 26, I investigations for serious will be completed within 5 Survey findings, however, et that the January 17, 2007		4. The QMRP and Residential Direct the home from January 2007 — May 2 longer employed by the agency. The QMRP and RD were brought in to re and have been trained thoroughly on management. See response to W122.	007 are no current place them, incident	12/13/11
	(02-99) Previous Versions O					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/19/2007 FORM APPROVED OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) M	JLTIPLE		(X3) DATE SURVEY		
71101 B	or contraction	IDENTIFICATION NUMBER	A BUIL	DING	<u> </u>	CC	MPLETED
		09G094	B. WIN	G			尺 11/07/2007
NAME OF F	ROYIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6934 9TH STREET, NW WASHINGTON, DC 20012				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL L9C IDENTIFYING INFORMATION)	ID FROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOTTAG CROSS-REFERENCED TO THE APPLICATION CONTROL OF THE PROPERTY)			4 BHOULD BE	(X5) CDMPLETION E DATE
{W 149}	and April 8, 2007 In and, the investigati allegation of abuse submitted for revie Director of Operati	age 9 noidents were investigated; on report for the May 14, 2007 documented that it was w on May 24, 2007, and the ons signed it on May 25, 2007. FF TREATMENT OF	{VV 14				
	mistreatment, neglinjuries of unknowr immediately to the	naure that all allegations of ect or abuse, as well as a source, are reported administrator or to other rice with Stats law through ures.			See response to W149.		12/13/07
	Based on staff inte medical and hability of the facility's included facility failed to repo	is not met as evidenced by: rviews, review of Client #4's ation records as well as review itent management policy, the ort all allegations of abuse in deral and state regulations and	,				
	progress note in CI "counselor" reported there had been an and a peer. On Oc Client #4 alleged the in the face. Interviet that she thought the first reported the all The nurse then not further indicted that incident because si	s: 9. According to a nursing lent #4's medical chart, a d to a medicalication nurse that altercation between Client #4 stober 28, 2007, at 9:30 PM, at Client #1 had punched him aw with the QMRP revealed a client, not a counselor, had legation of abuse to the nurse ified the QMRP. The QMRP is she had not viewed this as an ac categorized Client #4's a acousation. Neither she nor					
	07/04 00				<u></u>		

DEPART	IMENT OF HEALTH	AND HUMAN SERVICES					APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A, BU		TIPLE CONSTRUCTION NG	(X3) DATE SU COMPLE		
		09G094	B_ Wi	NG_		R 11/07/2007		
NAME OF P	ROYIDER OR SUPPLIER	·			REET ADDRESS, CITY, STATE, ZIP CODE			
CARECO	05				6934 9TH STREET, NW WASHINGTON, DC 20012		e e	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY PULL SC IDENTIFYING INFORMATION)	ID PREF TAC	X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
{W 153}	Continued From pa	ge 10	{W 1	(53)	}			
	the nurse had docu abuse on an incide agency policies. For review revealed no allegation was imm	mented the allegation of nt report, in accordance with urther interview and record evidence that Client #4's ediately reported to the or the Department of Health as		,				
 - 	Previously, the Sep	tember 28, 2007 survey	-					
,	failed to ensure all and allegations of a reported to the adm in accordance with DCMR Chapter 35,	and record review, the facility injuries of unknown source abuse, were immediately ninistrator and to other officials State law (DC regulation 22 Section 3519.10), for three of ing in the facility. (Clients #1,						
	investigations on S at 4:22 PM reveale provide evidence the	icility's incident reports and eptember 25, 2007 beginning of that the facility failed to not the following incidents were not the administrator and/or				•		
	#1 and #4 were in a resulted in Client # services to address Review of the emel	2007 staff reported that Clients a physical altercation that 1 needing emergency medical an injury to his lower lip.	·.		1. a. See response to W149 #4.		12/13/07	

received sutures to his lower lip laceration.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CARECO HRA

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PRINTED: 11/19/2007

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039* STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 096094 11/07/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6934 9TH STREET, NW CARECO 05 Washington, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DAT TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {W 153} Continued From page 11 {W 153} b. On April 8, 2007, staff reported that Client #1 was verbally aggressive to his roommate Client 12/13/07 1.b. See response to W149 #4. #4. According to the incident report, Client #4 was kicked by Client #1 and then Client #4 bit Client #1 on the left side of his wrist. (W 154) 483.420(d)(3) STAFF TREATMENT OF {W 154} CLIENTS 12/13/07 The facility must have evidence that all alleged See response to W149 violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on staff Interviews, review of Client #4's medical and habilitation records as well as review of the facility's incident management policy, the facility failed to investigate all allegations of abuse in accordance with federal and state regulations. (Residents #1, #2, #3, #4, #5) The finding Includes: Cross-refer to W149. According to a nursing progress note in Client #4's medical chart, a "counselor" reported to a medication nurse that there had been an altercation between Client #4 and a peer on October 28, 2007. At 9:30 PM, a medication nurse documented having assessed the client and found no sign of injury. The nurse did, however, administer Tylenol 650 mg that evening "for pain" after the attercation. On November 7, 2007, beginning at approximately 5:30 PM, interview with the QMRP revealed that she had been onsite that evening (October 28, 2007), working with Client #1 in the dining room. According to the QMRP, Client #4 told the medication nurse that Client #1 had

PRINTED: 11/19/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (XX) MULTIPLE CONSTRUCTION (X3) DATE SURVEY DIPLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING 09G094 11/07/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6934 9TH STREET, NW CARECO 05 WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (XS) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY**) (W 154) Continued From page 12 (W 154) punched him in the face. The nurse promptly came to the dining room and notified the QMRP. She said Client #4 had not told anyone about the alleged attack before the nurse arrived. Careco's Policies and Procedures Manual (manual) was reviewed, beginning at approximately 6:10 PM. "Allegation of abuse" was listed, or categorized as a "Serious Reportable Incident," A Serious Reportable Incident was defined as; "A reportable incident which, due to its significance or severity, requires immediate notification to, and investigation by. external authorities, in addition to internal review and investigation by the provider agency..." The QMRP reportedly interviewed the two clients: however, there was no written documentation. available to verify that she had initiated an investigation. She said she had not interviewed the other staff person who was onsite that evening. There was no evidence that Client #4's allegation of physical abuse was thoroughly investigated by the QMRP. Because it was not reported up the chain of command within the agency, there had been no administrative investigation performed by the Incident Management Coordinator in accordance with facility policies, nor were investigation(s) conducted by outside entities as mandated by regulation. It should be noted that Clients #1 and #4 have a documented history of altercations between the two, some of which led to serious injuries that required treatment at hospital emergency rooms. For example, an incident report dated September 30, 2007 and its corresponding Investigation report, described how Client #1 bit Client #4 on

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DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES 8 MEDICAID SERVICES				FORM): 11/19/2007 (APPROVED	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. BU		IPLE CONSTRUCTION	(X3) DATE :		
	,	09G094	B. W	NG_		R.		
NAME OF P	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	11/0	77/2007	
CARECO	005			6	934 9TH STREET, NW VASHINGTON, DC 20012			
(X4) ID PRBFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEPICIENCY)	Urd ale	(XE) COMPLETION DATE	
{W 154}	the shoulder with litt broke the skin. Clie	tle provocation. The bite ent #4 was taken to an r immediate care and	{W 1	54)		· .		
	Previously, the Sept findings included:	tember 28, 2007 survey	·					
	Based on interview : failed to ensure that neglect were thorou	and record review, the facility all allegations of abuse or ghly invostigated, for two of ng in the facility. (Clients #1				·	1.5	
	The findings include	:		.			,	
-	2. The facility failed investigation was co abuse, as follows:	to ensure a thorough inducted for all allegations of			2. See response to W122 and W125	•	12/13/07	
	investigations on Se at 4:22 PM, revealed reported that Client in his roommate Client	r's Incident reports and ptember 25, 2007, beginning a that on April 8, 2007, staff #1 was verbally aggressive to #4. According to the incident ded Client #4 and Client #4 bit side of his wrist.						
	completed for the afa Review of the summ documented only two of the actual incident There was no evider statements had beer	ory Report" had been orementioned incident. ary, however, revealed that it components, a restatement and recommendations. It is collected and reviewed to ent. Additionally, there was						

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/19/2007 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY 10 PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING D9G094 11/07/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6934 9TH STREET, NW CARECO 05 WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY {W 154} Continued From page 14 {W 154} no documentation indicating whether the incident had been substantiated or unsubstantiated. At the time of the survey, the facility failed to show evidence that the aforementioned incident had been thoroughly investigated. {W 159} 483.430(a) QUALIFIED MENTAL {W 159} RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the Qualified Mental Retardation Professional (QMRP) falled to respond timely to previously-identified active treatment and/or support needs, for three of the five clients residing in the facility. (Clients #1, #2 and #3) The findings includes: 1. The September 28, 2007 recertification survey had revealed inconsistent implementation of 1. a. The QMRP will request the Psychologist, 12/13/07 Client #1's recommended cigarette smoking Psychiatrist, and Primary Care Physician to reduction, without evidence of coordination and recommend behavioral and medical (if needed) monitoring by the Qualified Mental Retardation interventions to assist the client in smoking Professional (QMRP). The November 7, 2007 cessation. Effective strategies must manage his

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follows:

revisit revealed continued inconsistent

implementation of the client's recommended

a. Even though the QMRP stated that Client #1"can only have three cigarettes per day," as recommended by the cardiologist and agreed to by the primary care physician and the client's

smoking plan and continued failure to coordinate

and monitor an effective intervention strategy, as

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a smoking schedule.

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constant demands and resulting behaviors when he

is frustrated by not being able to smoke, and must

property, and must include, but go beyond, setting

prevent him from harming himself, others, and

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A BUI		PLE CONSTRUCTION	(X3) DATE S	0_0938-0391 SURVEY (ETED	
	<u>. </u>	09GQ94	B, WI	(G		11/07/2007		
NAME OF P	ROMDER OR SUPPLIER		- , , , , , , , , , , , , , , , , , , ,	69	EET ADDRESS, CITY, STATE, ZIP CO 934 9TH STREET, NW /ASHINGTON, DC 20012		3772001	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	×	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
(W 159)	brother, he was obs cigarette before der morning of Novemb	ge 15 erved smoking his third parting for day program on the er 7, 2007 and key staff were stions on how to address the	{VV 1	59}	-			
	At 6:54 AM, Client in porch smoking a cig asked the Resident The client smiled as not yet had a cigare he thought that he hovertheless, the R cigarette and he smapproximately 8:02 the RD and asked thim to wait but then after he complied with dentures. The client morning) at approximate clients and staff for day program. At took a cigarette with at day program. At QMRP stated that Colgarettes per day."	f1 was observed on the front parette. At 7:18 AM, the client Director (RD) for a cigarette, the told the RD that he had the that morning. The RD said ad already smoked one. D gave the client another oked it on the front porch. At AM, Client #1 came back to for cigarettes. The RD asked gave him another cigarette lith a request to insert his to smoked it (his third that mately 8:10 AM. At 8:24 AM, loaded onto the van and left becording to the RD, Client #1 him to smoke during a break approximately 10:04 AM, the lient #1"can only have three as recommended by the seed to by the primary care lent's brother.						
	a set schedule. At 1 indicated that the clicingarette after break and a third after dinr however, she acknobeen outlined in a with the RD later, at revealed that the clicing	Client #1 had not established 0:12 AM, the QMRP ent normally smoked a fast, another one after lunch ler. Two minutes later, wiedged that this had "not ritten schedule." Interview approximately 1:40 PM, ent had been taking two o day program daily, whereas	٠.		l.b. See response to l.a. abov	/c.	12/13/07	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		09G094	8. WING				₹ 7/2007		
NAME OF F	ROVIDER OR SUFFLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE				
CARECO	0 06			6934 9TH STREET, NW WASHINGTON, DC 20012					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF CORRECT)	ULD BE	(X5) COMPLETION DATE		
(W 159)	the QMRP expecte Conversation betwee to day program depalso expected to tall day program. c. Client #1's Behawhich had expired anot provide direction the smoking issue, person was observed.	d him to take only one een the RD and Client #1 prior earlure indicated that the client ke two cigarettes with him to vior Support Plan (BSP), on September 18, 2007, did in to staff on how to address During the revisit, a staff ed offering him a cigarette as ving with a request to insert his	{W 1	59}	1.c. See response to l.н. above.		12/13/07		
	On November 7, 20 Client #1 approache cigarettes. The RD him when he got on He told the client the trying to help him to then asked him to licient hesitated, the work with me" and another cigarette if 8:09 AM, the client wearing his denture	2007, at approximately 8:02 AM, and the RD and asked for a replied he would give them to a the van to go to day program, at it was too early and he was a curb his amoking. The RD neer his dentures. After the RD said "I'll work with you, then offered to give the client he put in the dentures. At returned to the dining room as and the RD gave him a ptly smoked it outdoors.							
	that she had addrest October 20, 2007 to when asked at what for staff to allow him cigarettes, the QMF acceptable." When offered as a reward she replied "cigaret reward him in other	D:14 AM, the QMRP indicated seed the topic with staff at an alning session. At 10:15 AM, t point would it be acceptable to smoke more than three RP stated that was "not asked if a cigarette could be for complying with a request, tes are not a reward. No. We ways." The QMRP then the BSP had expired. She	·						

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUJI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	<u> </u>	09G094	B. WIN	lG		1	R 7/2007
NAME OF P	PROVIDER OR SUPPLIER 0 05			65	REET ADDRESS, CITY, STATE, ZIP CODE 934 9TH STREET, NW VASHINGTON, DC 20012		112001
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	ECTION HOULD BE PPROPRIATE	(X5) COMPLETION DATE	
{W .159}	expressed an experimental expressed an experimental exper	ctation that an updated BSP for review at the client's SP meeting, scheduled for 7. that review of the facility's armittee minutes for a meeting 30, 2006 revealed that the commended that Client #1's The BSP, however, had not a the committee made the	{W 1	59}			
	d. Facility staff doc behavioral outburst	umented at least two recent s, including one incident that hat were cigarette related, as			1.d. (1) See response to 1.a. above	t _a	12/13/07
	indicated that Client recently. It had brol took Client #4 to an tetanus shot. An indicated of corresponding investa, 2007, indicated the because he didn't hithen-roommate Clie and go to sleep, he and bit him on the slisted four recomme sure <client's and="" as="" cigarettes="" evide="" implementing="" infailed="" name="" observations="" recom="" recommendations.<="" show="" td="" the="" to=""><td></td><td></td><td></td><td></td><td></td><td></td></client's>						
	(2) At approximately #1's BSP revealed t	y 10:55 AM, review of Client that it had expired on			1.d.(2) See response to 1.a. abo)YC.	

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		AND HUMAN SERVICES			FORM): 11/19/2007 (APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ULTIPLE CONSTRUCTION		0938-0391
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		09G094	B. WING	Ĝ	4.416	R
NAMEOFF	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COL		07/2007
CARECO	0 05			6934 9TH STREET, NW WASHINGTON, DC 20012	25	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE ACTION OF CROSS-REFERENCED TO THE ACTION OF CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
{W 159}	Continued From pa	ge 16	{W 15	io.		 -
	September 18, 2007	7. The functional analysis	(** 15			
	identified seven like	ly antecedents for his targeted ors (non-compliance, verbal		1		
	aggression, verbal t	hreats, crying and using a				
` .	loud tone of voice in	idoors), including when he		}		
	due to task/ activity	nd when he could not smoke involvement.				
	_					
	(3) At approximately LPM Designated Nu	r 1:45 PM, the QMRP and the urse presented an Incident		1.d.(3) See response to 1.a. abo		-11
	report, dated Octobe	er 24, 2007. The nurse		riado) des response ar rial ano	vc.	12/13/07
	documented the clie	ent's repeated refusels to take tions. Review of the Incident				
	Summary Report, da	eted October 25, 2007.		,		
	revealed that staff h	ad refused to give him a				
	The client then beca	d referred him to the nurse. ame angry and refused to	•			
	comply with the nurs	se's requests (three times) to			,	
1	take his medications	5.				
	2. The September 2	28, 2007 recertification survey				
	nad revealed that the system to ensure cit	e QMRP failed to establish a ents had batteries available to		2. The QMRP will provide an active	treatment	12/13/07
	operate their TV rem	note controls. Specifically.		program for the person where he will purchase of batteries; alert staff who	n bie hatteriee	
	Client #2's remote w	ras without batteries and the sware. The November 7.		are low, so that they can be discarded buy and insert new batteries in the re-	1. and he can	' <u> </u>
	2007 revisit revealed	d continued failure to		ody said hiself new dancines in the re	mote.	
	establish a system to follows:	o address this need, as				
,						
	On November 7, 200	07, at 5:16 PM, Client #2 was	,			
•	the remote (marked	vision remote. He retrieved with his name) from his	•			
	bedroom, Inspection	revealed that the battery				,
	compartment was er said the remote had	npty. The QMRP and RD been "lost" after the				
1.	September 28, 2007	survey and they were				}
- 1	surprised to see it re RD offered to seciet	appear that afternoon. The Client #2 with buying new				
	<u>_</u>	<u>. </u>	_	<u> </u>		
DRM CMS-256	7(02-88) Previous Versions C	Obsolete Event ID: CSKJ12	ı	Facility (D: 09G094 If co	rdinuation sheet	Page 19 of 20

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27, 2007, at 1:58 PM, to ascertain Information regarding Client #1's smoking practices. According to the nurse, there was no schedule

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	OF CORRECTION	IDENTIFICATION NUMBER:	A BU			CONSTROLLOR	(X3) DATE COMP	LEYED
		09G094	B. WI	NG.			.	R /07/2007
NAME OF I	PROVIDER OR SUPPLIER			51	TREET	ADDRESS, CITY, STATE, ZIP		, O112.001
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	ID PREF TAG	TX.		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROFRIATE	COMPLETION DATE
(W 159)	Continued From pa	ge 20	 {W 1	59	9)			
	Implemented to ass	ist the client with reducing his	ί	,				
	tobacco Intake. The was given \$5.00 we	nurse stated that the client ekly that he used to purchase						
	cigarettes. The nun	se further indicated that the						
	client maintained his	s own cigarettes.						
	On September 26, 3	3007, at 7:37 AM, Client #1						
•	was seen taking a c The Resident Direct	igarette outside to smoke. t (RD) was asked if Client #1						
	was on a schedule.	He replied "He should have						
	4 cigarettes per day 1 after breakfast 1 :	, per his physician's orders after return from day program			-{	•	·	
	at 4:00 PM, 1 after h	nls evening hygiene and he			1			
	takes 1 to day progr indicated that the cli	am." The RD further ent was "really resourceful"			1			
	and received cigare	ttes from peers outside of the			1			
)	facility (exact source reportedly became (not known). The client upset when told to limit his	i		1	,		
	smokes; he knew th	ey were "his own personal				, .	•	
	propertyhe buys th	nem that makes them his."						
	Interview was condu	icted with the QMRP on						
	Saptember 27, 2007 Client #1's smoking	, seeking further clarity about practices. The QMRP stated						
į	that no schedule had	d been implemented to assist						
	Client #1 with a redu	oction on his tobacco intake.						-
	On September 28, 2	007, at 6:20 PM, a follow-up						
	interview with the RI sought input from Cl	D indicated that he had lent #1's brother, in a	*					
	telephone conversat	ion just minutes earlier. The			ĺ			
	cigarette issue he'	really struggling with the son a set number of				·.		
	cigarettes a day w	e πeed to do something with	•					
	nis doctor's orders a staff, pocket books.	nd IHP he has stolen from . I know that he smokes at				·		•
	his day program too.	" At 7:11 PM, a direct	,					
	support staff person asked about Client#	approached the RD and 3's cigarettes. The RD						

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NO PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/		(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G094	B. Wil	B. WING			₹ 7/2007
NAME OF F	ROMDER OR SUPPLIER		<u>-</u>	112.001			
(X4) ID PREFIX TAG	FIX CEACH DEFICIENCY MUST BE PRECEDED BY FULL			ID FROVIDER'S PLAN OF CORREPRENTS (EACH CORRECTIVE ACTION SHOUSE ACTION SHOULD BE ACTION S			(X5) COMPLETION DATE
{W 159}	informed him that C and did not have m told the staff that Cl some of his with Cll hlm that he'll run ou smoke partner." W Cllent #1's cigarette pack out of his pool adding "they are no At the time of the st facilitate an interdisclient's smoking-relicardiologist's recomhis tobacco intake.	client #3 was out of cigarettes oney to purchase more. He ient #1 was free to share ent #3 if he wanted, "but tell it faster with sharing with his hen the staff asked where is were kept, the RD pulled a ket and handed it to the staff, win his possession." LIVEY, the QMRP falled to ciplinary team review of the ated needs, to address the impendation for a reduction in	{W 1	59}			
	ensure clients had I their TV remote cor On September 26, 2 AM, Client #2 open broke." The RD repremote." This surve him the TV. Once I support staff person It was quickly deten batteries in the remote he had been using I change channels (but the same brand of rinformed the client #2's record revealed no evident with budgeting for sinterviewed later the	d to establish a system to patterles available to operate strols, as follows: 2007, at approximately 8:40 by declared that "my TV olled "you have lost your eyor asked the client to show in the badroom, a direct in presented a remote control, mined that there were no ote. Client #2 confirmed that it. He then demonstrated how his roommate's remote to ooth of their TVs responded to remote control). The RD then that it was a matter of my your own batteries." Review I on September 28, 2007 to that he received assistance such purchases. When at day, the QMRP indicated usly unaware that the client			2. See response to #2 above.	(p.19)	12/13/6

PRINTED: 11/19/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0936-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G084 11/07/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6934 9TH STREET, NW CARECO 05 WASHINGTON, DC 20012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LEC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {W 159} Continued From page 22 {W 169} was out of batteries for his remote. She also acknowledged that there had been no budget developed to assist the client with planning for such purchases. 3. Cross-refer to W212. The QMRP failed to 3. See response to #3 above. (p. 20) 12/13/07 ensure comprehensive assessment of Clients #1 and #3's psychiatric conditions/ needs. {W 212} 483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN (W 212) The comprehensive functional assessment must Identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on interview and record review, the facility 12/13/07 See response to #3 above. failed to ensure a comprehensive psychiatric assessment had been conducted for both of the two clients (out of three sampled clients) in the sample who were prescribed psychotropic medications for behavior management. (Clients #1 and #3) The findings include: The September 28, 2007 recertification survey had revealed that the QMRP failed to ensure comprehensive assessment of Clients #1 and #3's psychiatric conditions/ needs. On November 7, 2007, at 3:27 PM, the QMRP stated that neither client had received an updated psychiatric evaluation. The consulting psychiatrist reportedly was attending an out of town conference. She further Indicated that a November 21, 2007 meeting was scheduled with the psychiatrist to

FORM CMS-2567(02-88) Previous Varsions Obsolete

"review all individuals on psychotropic

medications." It should be noted, however, that Client #1's interdisciplinary team was scheduled

Event ID; CSKJ12

Facility ID: 09G094

If continuation sheet Page 23 of 29

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CENTE	RS FOR MEDICAR	H AND HUMAN SERVICES E & MEDICAID SERVICES			- -		FORM	: 11/19/200 APPROVEI : 0938-039	
STATEMENT AND PLAN (TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ILTIPLE CON DING	(X3) DATE SURVEY COMPLETED				
		09G094	B, WING	G		R ·			
NAME OF P	ROVIDER OR SUPPLIER			6934 9TH	RESS. CITY, STA STREET, NW GTON, DC 20		11/07/2007		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((PROVIDER'S PLEACH CORRECTIONS - REFERENCI	AN OF CORRECT	ひいひおき	(X5) COMPLETION DATE	
(W 212)	Continued From p to meet before the review an update	7, on November 16, 2007, to	{W 21	2}	<u>,-</u>				
	地 斑啶钠 <u>物物加加加加加加加加加加加加加加加</u> 加加加加加加加加加加加加加加加加加加加加	**************************************				7			
	Previously, the Se findings included:	ptember 28, 2007 survey							
	failed to ensure a assessment had be two clients (out of sample who were medications for be	w and record review, the facility comprehensive psychiatric neen conducted for both of the three sampled clients) in the prescribed psychotropic chavior management. (Clients	·						
	#1 and #3) The finding include	₹S;		_				(.·	
	September 25, 200 both Clients #1 an medications to add This was verified the evening medication.	Resident Director on 07, at 2:33 PM, revealed that d #3 received psychotropic dress maladaptive behaviors. hrough observation of the n administration on September 1's Annual Medical Evaluation,							
	dated September: of Intermittent Exp date of diagnosis r the Qualified Ment (QMRP) and review	25, 2007, reflected a diagnosis losive Disorder (source and not indicated). Interview with al Retardation Professional w of Clients #1's and #3's					<u>.</u>		
	evidence of a com assessment that d diagnosis and justi psychotropic media	nber 27, 2007 failed to provide prehensive psychlatric ocumented each client's Axis I lifted the use of the prescribed cations.			•				
(W 225)	•	IDIVIDUAL PROGRAM PLAN re functional assessment must	{W 22!	-	e QMRP and Do oprehensive voo	DS will provide ational assessme	the ent.	12/13/07	

Event ID: C5KJ12

Facility ID: 09G094

If continuation sheat Page 24 of 29

CARECO HRA

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PRINTED: 11/19/2007

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM,	11/19/2007 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	IRVEY	
		09G094	B. WI	/G_		R 11/07/2007		
	ROVIDER OR SUPPLIER			ī	REST ADDRESS, CITY, STATE, ZIP CODE 6934 9TH STREET, NW	<u> </u>		
CARECO	• 05 				WASHINGTON, DC 20012			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIDEFICIENCY)	LILD BE	(X5) COMPLETION DATE	
(W 225)	Continued From pa include, as applicab	·	{W 2	25}	 			
	Based on interview falled to ensure that comprehensive voc	ational assessments as the three clients in the				-		
	had revealed that the comprehensive voce #2. On November 1 AM, Client #3 told the going to day prograshopping instead the nurse's office, Clipb." Minutes later, room table and beg approximately 7-46 comment "I want and he said "I want a negative voca want and the said "I want a negative voca want want and the said "I want a negative voca want want and want a negative voca want want a negative voca want want a negative voca want want want want want want want wan	2007 recertification survey the QMRP failed to ensure a stronal assessment for Client 7, 2007, at approximately 7:15 his surveyor that he was not me that day; he was "going At 7:37 AM, while seated in the client sat at the dining an eating breakfast. At PM, he repeated the other job." Then at 7:49 AM, w job."		-				
	Professional (QMRI #3's day placement program had "move days per week. On he was performing community gym. SI both said the client about wanting a new acknowledged that comprehensive voc review confirmed th	alified Mantal Retardation) was asked about Client She said his vocational d him to another location two Tuesdays and Wednesdays, anitorial duties at a ne and the Resident Director had not complained to them v job. However, the QMRP Client #3 had not received a ational assessment. Record is and Indicated that he had activity Program" (vocational)						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/19/2007 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERSUPPLIER/CLA JDENT/FICATION NUMBER:	(X2) N		TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	
		09G094	B. WI	NG.			२ 7/2 9 07
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 6934 9TH STREET, NW WASHINGTON, DC 20012	·	
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{W 225}	the facility had soug vocational assessm current interests, st [Note: In follow-up stated that Client#2 scheduled to meet	There was no evidence that ght a comprehensive lent, describing the client's	{W 2	225	5}		
	findings included: Based on observatireview, the facility freceived comprehe	tember 28, 2007 survey on, interview and record alled to ensure that clients nsive vocational assessments e of the three clients in the					. (
	The findings included on September 27, 2 AM, the Resident D #2 performed volume a nursing home. The just been informed the client had done that the nursing hor there on a permaner reportedly planned government case we	2007, at approximately 8:15 irector (RD) stated that Client teer work in the dining area of the RD indicated that he had by Client #2's job coach that so well during the "trial period" ne wanted him to continue ant basis. The job coach					
	September 27, 200	ved at his day placement on 7, beginning at 9:67 AM. The utensils in individual plastic					

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	•	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/19/2007 APPROVED 0938-0391
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	1.114	
CAREC	0 05			1 "	934 9TH STREET, NW VASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{W 225}	bags. He did so will job coach or his peet he and three other or placed the eating ut ice water, at the restlunch. The coach did my best workers." #2 had been volunted 1 month, "preparing stated that the clien polite." The job coach indic period was schedule (December), however to stay because he peers did not earn at their work. They wo Monday-Friday, between the clien asked "I'm golin right?" After the clien acknowledged that the said that the said that the said that the coach indicate which was said that the sa	chout any assistance from his eas. His job coach stated that volunteers with disabilities ensils, along with napkins and idents' place settings before escribed the client as "one of according to the coach, Client eering there for approximately him for employment." She twas "well-mannered and atted that Client #2's trial ed to end in 3 months er, she would "by to get him is very good." He and his a stipend or receive a wage for lunteered at this work site ween 9:00 AM - 2:00 PM. #2 approached the job coach g to make more money, ent walked away, the coach money meant something to while he was already	{W 2	225}	DEFICIENCY		
	hlm. She said that while he was already motivated, she thought that he "would be even more motivated if he got a check in hand." At the time, there was only one paid staff in the dining area, the nursing home's dining room supervisor. This was verified a few minutes later through interview with the supervisor. She was the sole paid employee. She also confirmed that Client #2 "enjoys his work and is doing well." At approximately 10:30 AM, the coach indicated that to date, she had not met either the Qualified Mental Retardation Professional (QMRP) of RD; neither individual had visited the current setting. When asked about Client #2's strangths, the		,				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	4ULT	TIPLE CONSTRUCTION	<u> </u>	(X3) DATE S	<u>. 0938-03</u> 91	١.
	DI CORRECTION	IDENTIFICATION NUMBER:	A. BU				COMPL		
		09G094	B. Wil	NG_			4416	R	
NAMEOF	ROVIDER OR SUPPLIER		·	ST	REET ADDRESS, CITY, SY	CATE ZIR COOR	1 1/0	7/2007	_
CARECO	05			ξ.	934 9TH STREET, NW	PATE, ZA CODE			
				1	WASHINGTON, DC 2	0012	•		
(X4) ID PREFIX	SUMMARY STATE	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID		PROVIDER'S F	LAN OF CORRECT	TION	(XS)	-
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(W 225)	Continued From pay	ge 27	(W 2	253				· ·	4
		catches on very well can	1002	Z - J J					
·	perform most tasks	after one demonstration is						1	
	independent in silve	rware, wiping tables, pretty	1		}				
	client as distractible	however, she described the							
	currently employable	e, she responded "yes."							I
		•							ĺ
	Later that day, the R	RD and QMRP were asked					·		
	RD confirmed that h	y placement. At 5:24 PM, the le had not observed the client							Ì
	performing work tas	ks at the current location. At	·						l
	approximately 5:29 !	PM, the QMRP also			}	•			l
-	acknowledged that s	the had not visited the current							l
	received a telephone	however, report having e call from the job coach on				-			l
	the previous day. The	he coach reported that the							l
	client was "doing we	II." She confirmed that while					•	(. :	•
	the other clients wer	e leaving the work site in		.		0	1		ĺ
	pecember, they war	nted "to keep him" at the case conference was							l
	planned for within the	e coming month (October) to							l
	discuss the proposal	l. When asked about a							ļ
	vocational assessme	ent, the QMRP stated that		.		•	_		Ì
	been performed.	ether an assessment had	•					·	l
	On September 28, 2	007, beginning at 9:53 AM,							l
	review of Client #2's	record falled to show]					
	evidence tr <u>at</u> ne nad Vocational assessme	I received a comprehensive ent to determine his interests.					·		
	skills and training ne	eds. There was however - !						j	
	an annual report (dat	ted April 30, 2007) that was		- 1					
1	prepared by the clien	it's current day program. The while he was a "very hard							
].	worker." he required	while he was a "very hard "verbal prompts throughout				•			
<u>}</u> 1	the day to remain on	task." The day program			•			j	
	plan for the coming y	ear included a	•	.	•			ł	
	recommendation to "	explore community based							
	ernhiological abboutal	nities" by exposing the client			-			1	

FORM CMS-2587(02-09) Previous Versions Obsoleta

Event ID: C5KJ12

Facility ID: 00@094

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/19/2007 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ID PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING R B. WING 09G094 11/07/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6934 9TH STREET, NW CARECO 05 WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION Ø PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XS) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAĞ TAG DATE DEFICIENCY) {W 225} Continued From page 28 (W 225) to "at least 2 community-based employment opportunities per quarter," It should be noted that further interviews with Client #2 and residential staff confirmed that money was important to the client and that he enjoyed making purchases. According to the RD, the client was responsible for purchasing batterles for such items as his TV remote control. At the time of the survey, there was no evidence that Client #2's interdisciplinary team had a comprehensive vocational assessment, describing the client's current interests, strengths and needs, available for discussion at the upcoming case conference. It was proposed to keep the client placed in a volunteer position with no opportunity for advancement to a paid position of employment It should be further noted that on September 28, 2007, at 4:51 PM, Client #2 enthusiastically declared to that he had received a paycheck that day. Payment was for "contract work" that he had performed during a recent period he apent working at a sheltered workshop, and not at the volunteer work site.

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FORM CMS-2567(02-66) Previous Versions Obsolets

Event ID: C5KJ12

Facility ID: 09G094

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDII B. WING	TIPLE CONSTRUCTION	(X3) DATE S COMPLE	TED			
09G094					R 11/07/2007			
IAME OF F	ROVIDER OR SUPPLIER				STATE, ZIP CODE	1 1110	172001	
CARECO			WASHIN	H STREET, N IGTON, DC 2	IW R0012			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID FREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLEY DATE	
{1 000}	INITIAL COMMEN	rs		{ 000}			 -	
	7, 2007 to determin previous deficiencie 2007. The findings observations, interv	was conducted on No ie the facility's compli es cited on Septembe of this survey were to riews with direct suppleand clients, and the in order the reports and	iance with et 28, pased on oott and					
		ERVICE / DINING AR	EAS	{ 042}				
ĺ	Modified diets shall	be as follows:			1	ļ		
ĺ	(b) Planned, prepar who have received i and	ed, and served by ind Instruction from a die	līvīduals titian;				1	
	Based on interview falled to ensure that residents were train residents dietary ne	met as evidenced by: and record review, th all persons working ed to effectively mee eds, for 4 of the 6 res y. (Clients #1, #3, #4	e facility with t the sidents					
1	The finding includes		·			-		
	Correction, signed C provider Indicated th provide "appropriate	tted a written Plan of October 25, 2007, in v lat the Nutritionist wo dietary managemen	nid	-		-		
1	However, review of a records and interview Retardation Professi revealed that training The QMRP stated th	November 2, 2007, staff in-service training we with the Qualified lonal on November 7 g had not yet been prest the Nutritionlet was additional training o	Mental , 2007 ovided.	·			,	
. [November 11, 2007,							

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If continuation sheet 1

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
09G094				B. WING_			/2007
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		1
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPRIDEFICIENCY)	(X5) COMPLETE DATE	
{1 042}	Continued From pa	ge 1	1	[1 042]			
	***********	**********	,	!			
· .	Previously, the Sep findings included:	tember 28, 2007 sur	vey				
	Based on observation, interview and record review, the facility falled to ensure that all persons working with residents were trained to effectively meet the residents' dietary needs, for 4 of the 6 residents residing in the facility. (Clients #1, #3, #4 and #5)					·	
	The findings include: 1. Dinner was observed in the facility on September 25, 2007 and breakfast was observed on September 26, 2007. At both meals, all six residents were served 2% milk. Residents #1, #3, #4 and #5 were all prescribed low cholesterol diets. In addition, Residents #1, #3 and #5 were prescribed reduced calorie (1800, 1800 and 1500, respectively) diets. On September 28, 2007, review of the menu revealed that residents who were prescribed low cholesterol and/or reduced calorie (1500, 1800) diets were to have skim milk. On September 26, 2007, review of staff in-service training records revealed no evidence of recent training on Nutrition, menus and/or prescribed diet plans. The most recent documented training had been provided on February 18, 2006 and only one of the employees who attended that session (19 months earlier) was still employed by the GHMRP. There was no evidence that the Residence Director, who was responsible for overseeing the purchase of menuitems, had received training by the Nutritionist.				The Nutritionist will provide training staff, including the Residential Director	g to facility or (RD).	12/13/67
	Resident #1's diet plan was changed on August 23, 2007, to reflect a restriction on daily			·		·	

Health Regulation Administration

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If continuation sheet 2 of 20

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STATEMENT OF DEFICIENCIES (X1) PROVIDĒR/SUPPLIER/CLIA (X3) DATÉ SURVEY (XX) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G094 11/07/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6934 9TH STREET, NW CARECO 05 WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE DATE PREFIX REGULATORY OR LOCIDENTIFYING INFORMATION) TAG TAG DEFICIENCY $\{1042\}$ Continued From page 2 $\{1042\}$ fluid intake. As per orders from the nephrologist 2. The Director of Disability Services (DoDS) will and primary care physician, his total fluid intake provide training to the Designated Nurse (DN), OMRP, and RD on ensuring that communication was not to exceed 1200 cc's dally, A newly-established schedule indicated that he and documentation is coordinated and accurate, should receive 6 oz with his afternoon snack, thereby providing better compliance with after return home from the day program. On recommended health service delivery. 12/13/07 September 26, 2007, at 4:21 PM, Resident #1 was observed drinking a 16.9 oz bottle of spring water with his snack. He finished the bottle in less than one hour. Subsequent review of staff In-service training revealed no documented evidence of applicable staff training. It should be noted that later that evening, at 6:16 PM, review of the resident's fluid intake chart revealed the Designated Nurse had documented 6 oz for the afternoon snack. When asked, she said the resident had been given 6 oz of juice. Subsequent interview revealed that neither the nurse, nor the Residence Director was previously aware that Resident #1 had taken a bottle of spring water. It remained unclear whether he drank the 16.9 oz of water and 6 oz of Juice. (I 071) 3503.2 BEDROOMS AND BATHROOMS [1071] The RD will move the bed to meet the distance Each bed shall be placed at least three feet (3 ft.) requirement from any other bed and at least three feet (3 ft.) from any unprotected radiator. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that two residents' beds were at least 36 inches apart. (Residents #4 and #5) The finding includes: The GHMRP submitted a written Plan of Correction, signed October 25, 2007, in which the

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C5KJ12

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If continuation sheet 4 of 20

	TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER		ERICLIA IMBER:	A. BUILDIN		(X3) DATE SURVEY COMPLETED R	
<u> </u>	09G094			B, WING			7/2007
NAME OF P	ROVIDER OR SUPPLIER		F		STATE, ZIP CODE		
CARECO			WASHING	STREET, N TON, DC 2			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REPERENCED TO THE DEFICIENCY	(X5) COMPLETE DATE	
{ 071}	Continued From page	ge 3		{l 071}		,	 _
	"review the physical manage the space pobservation of the b 2007, at approximation the two beds remain	net administrators will setting and determine requirements." However the determined in the same positions and in the same positions.	ine how to vever, per 7, ed that ition.				
	[Note: At 9:13 AM, the Resident Director stated that Residents #5 and #1 had switched bedrooms since the last survey.]			·			
	+++<++++++++++++++++++++++++++++++++++	**************************************					
	Previously, the Sept findings included:	tember 28, 2007 sur	vey		. · ·		
	On September 26, 2 #1's bed was observaway from Resident remained in their sa 28, 2007, at 7:00 PM	ved placed only 22.5 #4's bed. The beds me position on Sept	inches				
{(090)}	3504.1 HOUSEKEE	PINĠ		{1 090}			
	The interior and extermaintained in a safe and sanitary manner accumulations of directors.	e, clean, orderly, attra r and be free of	active,			·.·	
	This Statute Is not n Based on observation failed to maintain the facility in a clean, or	on and interview, the interior and exterio	GHMRP or of the				
]	The findings include	<u>.</u>					
	The GHMRP submit Correction, signed C	ted a written Plan of October 25, 2007, in	which the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G094			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVE COMPLETED R		
NAME OF E	PROVIDER OR SUPPLIER		STREET AC	DRESS, CITY	STATE, ZIP CODE	11/0	7/2007
CARECO			6934 9TH WASHING	STREET, N	1VV		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
(I 090)	Continued From pa	ge 4		{i 090}			
	provider Indicated that all environmental deficiencies would be corrected by November 2, 2007. However, inspection of the facility on November 7, 2007, beginning at approximately 9:30 AM, revealed that several previously-cited deficiencies remained, as follows:						
	Backyard and porch	Backyard and porch:					
	the back porch was appeared that nume	ndows and window si peeling, chipped and erous coats of paint h ars and the resultant ctive.	dirty. It				
	Kitchen:		•	·	·		1-
	The handle on the above the stove was not secured properly	ne upper left cabinet o s missing a screw an y	loor d was		The handle will be properly secure	đ.	12/13/07
	 Cabinetry throug unattractive, presum Basement: 	hout the kitchen was nably due to age and	notably wear.		Cabinetry will be maintained in go kept clean.	od repair and	الما والمدا
	There was a strip of length) missing at the right corner.	was a strip of molding (approx. 3 ft. in) missing at the base of the wall in the front corner.			Missing molding will be replaced.		12/13/07
	Living room:						
	There were 3 burn marks in the carpet that by their shape, appeared to have been caused by an iron.				The area rug will be replaced.		12/13/07
:	Resident bedrooms.		l				
Igalib Bacula	Both Resident #2 and Resident #3 had loose dresser drawers, filled with personal clothing						

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TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED			
	09G09 4		B. WING		R 11/07/2007		
NAME OF	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	1 11/0	7/2007
CARECO	05		6934 9TH WASHING	STREET, N STON, DG 2	IW 20012		
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	(X5) COMPLETE DATE	
{0e0 }	items, that were placed directly on the floor underneath their beds. Each resident had a bed, nightstand and wardrobe; the 2 drawers placed on the floor were their only dresser drawers			{1 090}	1. The residents have "captain's beds" for efficient use of space. The drawers the framework of the bed, and therefor to be "on the floor" but actually slide in the frame the way dresser drawers slide of the dresser's frame.	s are part of e may appear n and out of	12/13/07
·	2. There was a significant accumulation of dust in the bedroom shared by Residents #1 and #4, especially on the carpet in the corners, along the molding/ walls and on their window curtains.				2. The RD has specifically assigned sta with duties for dusting and laundering for the people who live in the home, th accountability for cleanliness and follo	assistance us increasing w up. The	12/13/07
	J. There was a bun inside the door to th Residents #1 and #	ciency. See Federal ated 10/12/06. n mark in the carpet e bedroom shared b 4. Judging by its sha ave been caused by	just y ape. the		room will be dusted and the curtains la regularly. 3. The area rug will be replaced.	umdered	12/13/07
(l 108)	3504.15 HOUSEKE Each GHMRP shall at least seven (7) ch to his or her dally ac	assure that each restanges of clothing apatrolities.	propriate	{I 108}			
, ,	This Statute is not r Based on interviews positions, the GHMF resident at least sev The finding includes	with staff in supervious realist to secure for the changes of clothless with the changes with the changes with the changes with the change	sory or each				
	The GHMRP submit Correction, signed Correction, signed Correction and cated the would replace the daitems identified in the Deficiency report by follow-up survey on that the residents re	October 25, 2007, in vat the Resident Director of the Resident Director of the Resident Director of the Resident Park 2007, the Rovember 7, 2007, the Rovember 8, 2007, the Rovember 9, 2007, the Rove	which the ctor ctor clothing 07 the evealed				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A, BUILDI B. WING		(X3) DATE COMP	SURVEY (
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADD			44/07/20				
CARECO			6934 9TH WASHING	STREET, I	. STATE, ZIP CODE NW 20012			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FILL)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
{I 108}	Continued From pa	ge 6		{I 108}			<u> </u>	
	supply of socks and undergarments. According to the Resident Director, at 8:40 AM, (and corroborated later by the Qualified Mental Retardation Professional) no new undergarments had been purchased since the last survey. Reportedly, there had been a delay in securing the necessary funds from the corporate office.							
`					·			
	Previously, the Sept findings included; 1. On September 2: 7:58 AM, Resident # wearing a pair of drecasual shorts and shis athletic socks all the next half hour, the Resident #1 and this resident's 12 athletic (Note: The 2 drawer undershirts and brief drawers were in gent socks without holes if morning. Resident # for day program.	5, 2007, at approximate was asked why he as socks while he woneakers. He complay had holes in them, a kesident Director, surveyor examined ventory. Ten of the socks had holes in them as with holes in them aral disarray.) There found in them on before the put them on before	ately was ore ained that During the them. of and the were 2 that e leaving		1. The RD will ensure that damaged : underclothing are replaced.	socks and	12/13/6	
	 On September 28 1:00 PM, inspection of inventory revealed 1 and no drass socks, 	of Resident #6's clot	hīna İ		2. The RD will ensure needed garment purchased, labeled, and provided to ear	s are ch person.	12/13/07	
1	3. On September 28, 2007, at approximately 7:05 PM, Resident #5's dresser drawers contained 1 pair of underbriefs.				3. See answer to #2 above.		דם אנו בו	
	On September 28, 20	07, at approximately	7:07				1.	
	tion Administration			·				

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	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		R/CLIA MBER:	A. BUILDIN	·	(X3) DATE S COMPL	ETED
		09G094					R 17/2007
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE ZIP CODE		
CARECO	05			STREET, N STON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
{ 108}	Continued From pa	ge 7	-	(I 108)			
	PM, the Resident Director acknowledged that the residents did not have at least 7 pairs of socks appropriate to his daily activities.						
{I 187}				{I 187}			
	Each GHMRP shall have an organization chart that shows the following:				The new organization chart will house.	be posted in the	12/13/07
·	(d) The lines of auth	nority,					
	Based on interview Retardation Profess failed to maintain ar	met as evidenced by with the Qualified Mo sional (QMRP), the G n organizational char authority within the r	ental HMRP t that				-
	The finding Includes	5.				•	
	The GHMRP submit Correction, signed Correction, signed Correction and cated the would be updated by However, interview 7, 2007, at 4:42 PM, seen a new chart er	nat the organizationa y November 2, 2007 with the QMRP on N , revealed that she h	which the I chart ovember ad not				
	available for review 8, 2007, subsequen submitted by the QN Information.	in the facility. On No t review of materials	ovember				
	**************	······································	·				
	Previously, the Sept findings included;	ember 28, 2007 sun	vey:		·		
	The organizational of that was made availables Administration	chart (dated Septem) able for review on S	ber 2007) eptember	<u> </u>	,		

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	TEMENT OF DEFICIENCIES OF PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G094			(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
NAME OF P	ROVIDER OR SUPPLIER	000007	STREET ADI	DRESS, CITY :	STATE, ZIP CODE	1 1/0/	//2007
CARECC			6934 9TH	STREET, N TON, DC 2	w		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REPERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
(l 187)	27, 2007, at 2;49 Pl lines of authority wi	ge 6 M, did not reflect the thin the nursing depa -hired RN Superviso	ertment, to	{ 187}			
{1 206}	Each employee, pri annually thereafter, certification that a h performed and that would allow him or duties. This Statute is not Based on interview GHMRP failed to el prior to employment provided evidence of that documented a performed and that	EL POLICIES or to employment an shall provide a physicalth inventory has to the employee 's her to perform the remark as evidenced by and record review, to sure that each empt and annually there of a physician's certificalth inventory had the employee's healther to perform the reservant and annually there are to perform the reservant and the employee's healther to perform the reservant and the employee's healther to perform the reservant and annually there are to perform the reservant and the employee's healther the emp	ician 's been alth status cquired the loyee, after, ication been th status	{1 206}			
	revealed no evident for one nurse and for identifier was include that was sent to the The GHMRP submictorrection, signed of provider wrote: "The Department will accompletion date of On November 7, 20	007, however, there v	nventories taff by report five office. f which the licates " with a				
	evidence of current	health certificates in	the			<u></u> .	· · · · · ·

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If continuation sheet 9 of 20

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		09G094	•	B, WING_		11/07	7/2007
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, :	STATE, ZIP CODE	11101	14001
CARECO	005			STREET, N TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XS) COMPLETE DATE
(1 206)	Continued From pa	ge 9		{I 208}			
	Mental Retardation that she would seek corporate office and regulatory agency.	nately 4:50 PM, the C Professional (QMRF documentation from I forward them to the On November 8, 200 on submitted by the C ng:	o) stated in the or, review				
	The health inventory for the nurse cited in the previous survey (S5) had expired, it was dated September 16, 2006; and,				The Human Resources Director will prequired documentation for the nurse an consultants.	rovide the	12/13/07
		pdated health invent ur consultants cited : 1, C3, C6 and C7).			2. See response to #2 above.		12/13/07
	*************************************	*****				,	
	Previously, the Sep findings included:	tember 28, 2007 sur	vey				
	Professional and re personnel files on S the GHMRP failed to	Qualified Mental Reta view of the GHMRP' september 27, 2007 i oprovide evidence t icates were on file fo sultants.	s revealed hat				
	This is a repeat def Deficiency Report d	iciency. See Federa lated 10/12/06.	ıl				
(I 223)	3510.4 STAFF TRA	NNING	-	{I 223}		•	
	participation shall b	am agenda and reco e maintained in the (view by regulatory ag	SHMRP		The DoDS will provide the agenda	s used.	12/13/07
Joseph Radiu		met as evidenced by and record review, t					

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If continuation sheet 10 of 20

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X9) DATE S COMPLE F	ived S
NAME OF R	ROVIDER OR SUPPLIER	09G094	STREET AN	DRESS CITY S	STATE, ZIP CODE	11/0	7/2007
CARECO			6934 9TH	STREET, N' STON, DC 20	W		•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE AFFROPRIATE	(X5) COMPLETE DATE
{1,223}	GHMRP failed to en maintained in the g available for review The September 28, revealed no evidence	- nsure that agendes w roup home and made	ey had ht staff	{1 223}			
	October 25, 2007, I "The QMRP will pro- agendas that were completion date of Staff in-service train	ning records were rev	wrote: andard ," with a viewed in				
	9:56 AM. There was training conducted October 20, 2007 or Supervision" and "E no corresponding a review. At approximand RD acknowledgavailable to venify the conveyed. In additional additional acknowledgavailable to venify the conveyed.	vember 7, 2007, beging a staff signature of by the QMRP and the in the topics "Staff Documentation." The genda, however, avainately 4:56 PM, the Oged that there was not information that he on, the QMRP did not opics of "the standard."	neet for RD on re was illable for QMRP dagenda ad been ot offer				
·		gs cited in the previo					
	findings included: On September 26, 2 review of the GHMF records revealed the	tember 28, 2007 sun 2007, beginning at 3: RP's staff in-service t at there were no age	24 PM, raining ndas				
Haalth Paru	by staff signature si	g sessions that were neets. For example, to r handouts to indicate	here	-			

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If continuation sheet 11 of 20

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A BUILDIN	PLE CONSTRUCTION G	(X3) DATE SI COMPLE	TED
		09G094		1 0, 14(10			7/2007
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
CARECO	05		6934 9TH 8 WASHINGT	TREET, NOT 2	W 0012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{ 223}	Continued From pa	ge 11	, .	[1 223]			
	subject matter disci	ussed at the following	a:		'		·
	- September 6, 200 Safety, Electrical Sa	7 "Fire Safety, Cook afety;"	ing				
	- July 23, 2007 and	August 11, 2007 "Se	exuality;"				
	- August 8, 2007 "15	SPs/Active Treatmen	t:"				
	- July 19, 2007 "Rights of Persons with MR/DD Most Integrated Setting;"						
	- August 8, 12 and Professional Couns	13, 2007 "Role of Th selor," and	e				. •
	other recent training The Workplace," "S Care" and "Sign La	g on such fopics as " Securing Medical and nguage,"	Ethics in Dental				
	review were those t	he only agendas ava hat were brought by by presented training	DDS				
{I 2 29}	3510.5(f) STAFF TI	RAINING		(1 229)			
	Each training progra limited to, the follow	am shall include, but /Ing:	not be				
	residents to be sen to, behavior manag	related to the GHMR red including, but not ement, sexuality, nui nmunications, and a	limited trition,				-
Joseph Daniel	Based on interview GHMRP failed to en	met as evidenced by and record review, to asure that agendas we roup home and made	he Vere			·	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
<u> </u>		09G094	-	a. WING_		11/07/2007	
NAME OF P	ROYIDER OR GUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
CARECO	0 05			STREET, N' TON, DC 2			.
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRICIENCY)	ULD BE COMPLET	
(i 229)	Continued From pa	ige 12		{I 229}			
	The findings include	e:					,
	survey revealed the training by the Nutr February 18, 2006, who attended that swas still employed	042. The September at the most recent do itlonist had been proving Only one of the empsession (19 months eby the GHMRP. The Correction, signed October 1986.	cumented vided on ployees earlier)		1. The Nutritionist training will be res	scheduled.	67
	2007, stated that for November 2, 2007, records were review November 7, 2007, was no documente had provided in-ser Mental Retardation acknowledged that conducted the train	aining would be provided to staff in-service train wed in the GHMRP or beginning at 9:56 All devidence that the Notice training. The Quarter Nutritionist had noting to date; however, eduled to provide additional in the Notice training to date; however, eduled to provide additional in the Notice and the Notice additional to date; however, eduled to provide additional in the Notice and the Notice additional to date; however, eduled to provide additional in the Notice and the Notice a	ided by ning n M. There lutitionist ualified >) not she				_
	Resident #4 (who very survey), had a diag Review of the staff beginning at 9:56 A recent documented provided on January earlier). The GHMI that training regard provided by Novem of the staff in-service November 7, 2007, revealed no eviden 6:08 PM, the QMRI training had not yet further stated that the survey of the stated that the survey of the page 12.00 pm.	28, 2007 survey revevas not in the sample thosis of seizure diso in-service training really, revealed that the I training on seizures y 30, 2006 (20 month RP's Plan of Correcting seizure disorder wher 2, 2007. However training at 9:56 Alice of training on seizure disorder the following of the training on seizure disorder that the courred; however, the Registered Nurse training for November 1950 and 1950 a	o for that rder. cords, most had been hs on stated would be er, review of M, ures. At the she		2. The RN Supervisor will ensure the training is provided and documented	nat seizure	
James Section	Stion Administration				<u> </u>	<u></u>	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 09G094		(X2) MULT A. BUILDII B. WING	TPLE CONSTRUCTION	(X3) DATE SI COMPLE F 11/0	TED
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CARECO	05			STREET, N TON, DC			•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
(1 274)	3513,1(e) ADMINIS	STRATIVE RECORD	s	(1 274)			-
		l mai ntain for each a on, at any tlme, the fo rds:					
	(e) Signed agreeme professional service	ents or contracts for es;					
	Based on Interview GHMRP failed to de	met as evidenced by and record review, to ocument signed writh tracts with profession	he ten				
-	revealed no evident contracts with three was included with the sent to the facility's GHMRP submitted signed October 25, wrote: "The Human	2007 licensure surve ce of signed agreeme consultants. A staffice deficiency report administrative office a written Plan of Co. 2007, in which the paresources Departs.	ents or fidentifier that was The rrection, provider nent will				
	with a completion of On November 7, 20 evidence of written	racts are on file in the late of November 2, 1007, however, there agreements or control	2007. was no racts in		The HR Director will provide the	signed consultant	12/13/07
	Qualified Mental Re (QMRP) stated that documentation from forward them to the November 8, 2007, submitted by the Q written agreements consultants identified	eximately 4:57 PM, in the would seek in the corporate office regulatory agency, review of the docum MRP revealed no ever or contracts with the ed in the previous su	nal e and On nentation idence of e three		contracts,		
Health Book	C4 and C5).	***********					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SI COMPLE	TED	
		09G0 6 4		B. WING_		11/0	7/2007	
NAME OF P	ME OF PROVIDER OR SUPPLIER STREET		STREET ADD	RESS, CITY, B	TATE, ZIP CODE			
CARECO	0 05			H STREET, NW NGTON, DC 20012				
(X4) ID PREFIX TAG	(EACH DEPICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
{ 274}	Continued From pa	ge 14		(l 274)				
,	Previously, the September 28, 2007 survey findings included: Interview with the Qualified Mental Retardation Professional and review of personnel records on							
	September 27, 200	7 revealed the GHMI or written agreement	RP failed					
{l 379}	3519.10 EMERGE	NCIES		(I 379)			12/13/07	
	each GHMRP shall Health, Health Fact unusual Incident or interferes with a res arrangement, well t	porting requirement notify the Departme Ilties Division of any event which substan- sident's health, welf- being or in any other	nt of other itially are, living way		Sec response to federal delicien	-y W149.		
	be made by telepho followed up by writt	at risk. Such notifica one immediately and en notification within urs or the next work	shall be					
	Based on interview GHMRP failed to el Health, Health Reg notified of all allega immediately by pho	met as evidenced by and record review, to some that the Departulation Administration tions of physical abuing then followed up of the five residents #1 and #4)	he trnent of n, was ise, by written					
Health Bogu	Citation W149. Ac note in Resident #4 reported to a medic been an altercation	eral Deficiency Report cording to a nursing poly is medical chart, a "cation nurse that ther between Resident # 28, 2007, at 9:30 PM	progress counselor" 'e had '4 and a			·		

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TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SI COMPLE F	TED	
<u></u>		09G094		177		11/0	7/2007
NAME OF P	ROVIDER OR SUPPLIER			STREET, NV	TATE, ZIP CODE		
CARECO	0.05			TON, DC 20			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
(1 379)	Continued From pa	ge 15		{ 379}			
	punched him in the QMRP revealed that a counselor, had fir abuse to the nurse. QMRP. The QMRI not viewed this as a categorized Reside accusation. Neither documented the all incident report, in a policies. Further in revealed no evident allegation was Immadministrator and/orequired. It should	I that Resident #1 hat face. Interview with at she thought the rest reported the allega. The nurse then notice further indicted that an incident because some #4's allegation as a she nor the nurse he egation of abuse on a coordance with agent terview and record acceptately reported to the Department of be noted that the Ghaving investigated F	the sident, not ation of iffied the she had she a false an cy eview the Health as				
	ı.	itember 28, 2007 sur	vey		<u>.</u> •		
	GHMRP failed to e Health, Health Reg notified of incidents interfered with a rearrangements, well placed the individual phone then followe two of the six reside #1 and #4) The findings include Review of incident September 25, 200 revealed the GHMI	reports and Investiga 17, beginning at 4:22 RP failed to provide e acidents had been rej	trnent of n, was antially are, living r way y by cation, for lesidents ations on PM, evidence				

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STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G094 11/07/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6934 9TH STREET, NW CARECO 05 WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S FLAN OF CORRECTION (X4) ID PREFIX ī (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFOC REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) ·{| 379} Continued From page 16 $\{1379\}$ a. On January 17, 2007, staff reported that Resident #1 and #4 were in a physical altercation that resulted in Resident #1 needing emergency medical services to address an injury to his lower lip (laceration). b. On April 10, 2007, staff reported that Resident #1 needed to be picked up from the day program due to knee pain. The resident was subsequently seen at the emergency room and diagnosed with a knee sprain c. On April 18, 2007, staff reported that Resident #1 was verbally aggressive to his roommate Resident #4. According to the incident report. Resident #1 kicked Resident #4 who in turn, bit. Resident #1 on the left side of his wrist. d. On July 7, 2007, staff reported that Resident #4 eloped while staff were packing the van to return from the resident 's vacation in Ocean City, Maryland. This is a repeat deficiency. See Federal Deficiency Report dated 10/12/06. 12/13/07 {| 474} 3522.5 MEDICATIONS П 474} The Director of Operations, the DoDS, and the RN Supervisor will hold a meeting of all nurses to Each GHMRP shall maintain an individual review documentation to ensure that MARs and medication administration record for each progress notes, and incident reports are properly resident. and accurately completed. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP falled to ensure that nursing staff maintained Medication Administration Records (MARs), as follows: On November 7, 2007, at approximately 5:25 PM, a nursing note was found in Resident #4's medical chart that indicated on October 28, 2007, the resident had made an allegation of physical abuse. Resident #1 allegedly hit him in his face. The progress note Indicated that the nurse Health Regulation Administration

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NAME OF PROVIDER OR SUPPLIER	<u> </u>	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		72001
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and administered To "for pain." At approximately 5: #4's October 2007 that the nurse had administered the Type PM, after reviewing LPN Designated Nursing staff falled GHMRP's policies of the policies of the paintern of the policies of the paintern of th	#4, found no sign of ylenol 650 mg that e 43 PM, review of Re MARs revealed no e properly documented ylenol on the MAR. If the MAR herself, the marked on Resident is tember 28, 2007 sur to consistently imple on maintaining Medic	sident vidence I having At 5:50 e facility's hat she #4's MAR.	{1 474}			
Administration Recommendate September 25, 200 was given his mediathe pharmacy had reconstulose (prescribistory of constipation had been without Capproximately 6:30 MAR revealed the first September 23, 20 medication employed and documented "disable to the september 24, 20 september 25 september 24, 20 september 25 september 24, 20 september 25 s	ation pass was obse 7. At 5:38 PM, Residentions. The nurse shot delivered a new sibed to address Resident onstulose for 2 days PM, review of the resident of the part of the part of the see on the back of the part o	rved on dent #5 stated that supply of dent #5's , therefore . At esident's				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUT	R/CLIA MBER:	(X2) MULT A. BUILDIN	TPLE CONSTRUCTION	(X3) DATE SI COMPLE	TED
		09G0 94		B. WING_	<u> </u>	11/0	₹ 7/2007
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{ 474}	Continued From pa	ge 18		{1.474}			
	* September 24, 20 Initials and docume the MAR sheet.	07, 5 PM - A nurse on nted "on order"on the	ircled her back of				
	* September 25, 20 space blank, with n evidenced.	07, 7 AM - A nurse lo o other documentation	eft the on				·
	confirmed that the r Constulose had run She could not, there	ew with the Designate resident's supply of a out on September 2 afore explain why a n istering it the next ma	3, 2007. Jurse had				
{I 500}	that the rights of res protected in accord	S RIGHTS lence director shall e sidents are observed ance with D.C. Law a applicable District an	and 2-137; this	{ 500}	The Director of Operations and the I Supervisor will hold a meeting of all program management staff to cusure understand and implement Carcco's incident reporting and investigation	that they each policy on	12/13/
	Based on interview revisit on Novembe ensure each reside and have his/her coone of the five reside#4)	met as evidenced by and record review do record review do record review do record resistor to file a constitution of the facility. (uring the failed to plaint ated, for	·		- ·	
lealth Rock	the Resident Direct had been one incide since the Septembe survey. The corres	oo7, at 9:14 AM, inter or (RD) revealed that ent reported and inve or 28, 2007 recertificate ponding documentate AM, the RD stated that	there stigated ation ion was				

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NAME OF F	ROVIDER OR SUPPLIER	09G094	OZOCET AD	DDECO OFF	STATE, ZIP CODE	11/0	7/2007
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{ 500}	Continued From pa	~		{I 500}			
	approximately 1:35 Retardation Profess that no other incide September 28, 200 LPN Designated Nu time, stated that she	incidents reported. A PM, the Qualified Mostonal (QMRP) also into the had occurred single freertification surveurse, who was presented mursing care (exception refusal).	ental ndicated ce the ey. The nt at the ly other				
	PM, a nursing note medical chart that it allegation of physica 2008, Resident #4 it had punched him in Qualifled Mental Re (QMRP) on November 100 PM, revealed to peer-on-peer abuse accordance with fac QMRP Indicated that	ever, at approximate was found in Reside adjusted he had mad all abuse. On Octobe informed staff that Reside the face. Interview stardation Profession ber 7, 2007, at approphat the allegation of a had not been reportality policies. Althought she had interviewed.	nt #4's le an er 26, esident #1 with the al eximately ted in gh the ed the two				
	allegation, there wa available for review complaint had been there was no evider allegation was repo- including his mother care), in accordance	e the resident made, s no written docume to verify that the resi- investigated. In add nce that Resident #4' rted to outside entitle r (she remains Involve with facility policies plaint received appro-	ntation ident's dition, is es, red in his				
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER 09G094		IBER:	XI) MULT A. BUILDII B. WING		(X3) DATE SURVEY COMPLETED R 11/07/2007		
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{000 FI}	D) INITIAL COMMENTS			000}			<u> </u>
	September 25, 200 2007. A random sa selected from a res with various degree of this survey were group home and tw with residents and s guardian, as well as	was conducted from 7 through Saptember ample of three residen ident population of sixes of disabilities. The faced on observation of day programs, intenstaff and one residential the review of clinical ds, including incident	ts was men findings s at the views and				
(R 125)	The criminal backgr criminal history of the contract worker for in all jurisdictions wi employee or contract	JND CHECK REQUIR cound check shall disc to prospective employ the previous seven (7) which the prospect worker has worked even (7) years prior to	close the ree or rective	125)			(
	Based on interview failed to document of disclosed the crimin employee or contract seven (7) years, in a the prospective employeed or resided when to the check. The finding includes the September 28, in a series of the check.	2007 licensure aurvev	hecks pective pus vhich ker had ars prior				
	revealed no evidenc background checks staff Identifier was In report that was sent 2007, at 4:45 PM, th	e of comprehensive for two direct care staticuled with the deficient to Careco. On Noven	ff. A				·
ealth Regula	son Administration	-			TITLE	· <u></u>	(5) DATE

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(X3) DATE SURVEY TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A BUILDING B. WING 09G094 11/07/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6934 9TH STREET, NW CARECO 05 WASHINGTON DC 20012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) {R 125} Continued From page 1 (R 125) Retardation Professional (QMRP) stated that she thought the agency had run "global" background checks, to include all Jurisdictions in the United States, for every employee. She agreed to provide evidence of background checks for the two previously-identified employees, as well as for two newly-hired employees. On November 8, 2007, review of the documentation submitted by the QMRP revealed the following: 1. There was no documentation available to 12/13/67 1. The HR Director will ensure background checks verify compliance for the two employees cited in for the two employees are completed and are in the previous report (S1 and S2); compliance with regulations. 2. Instead of "global" background checks, the criminal court records searches that were 12/13/07 2. The HR Director will ensure that the 7-year documented for the two newly-hired employees history of all the jurisdictions where the two (S14 and S15) were limited to the jurisdictions in employees had lived and worked will be completed which they had lived during the previous seven per regulations. years: The GHMRP failed to disclose a seven vear history of all the jurisdictions where the employees had worked and/or alleged having included that factor when securing the background checks; therefore, verification could not be achieved. Previously, the September 28, 2007 survey findings included: Interview with the Qualified Mental Retardation Professional and review of the personnel records on September 27, 2007, at 7-21 PM, revealed that the GHMRP falled to provide evidence that criminal background checks were on file and disclosed a seven year history of all the jurisdictions where the employee resided and worked for two direct care staff. Health Regulation Administration

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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ealth Regulat	ion Administration			<u>.</u>			/(TOP)	·	

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